

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

592

CERTIFICATE OF DEATH

Reg. Dist. No.

00584

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy --rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>06 X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>E.</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lloyd S. Buckingham</u>	
14. MOTHER'S MAIDEN NAME <u>Susan Hood</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Clarence P. Baker, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Fractured right hip</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>20 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12 17</u> 19 <u>58</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Mt Airy</u> <u>Carroll</u> <u>Md.</u>
21. I certify that I attended the deceased from <u>12 Dec., 1958</u> , to <u>6 Jan., 1959</u> , that I last saw the deceased alive on <u>6 Jan., 1959</u> , and that death occurred at <u>7:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert H. Pilgram</u> M.D.		DATE SIGNED <u>Jan 9 '59</u>	
PHYSICIAN'S NAME (Type) <u>Robert H. Pilgram</u>		<u>Prof. Bldg., Frederick, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-9-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

593
CERTIFICATE OF DEATH

Reg. Dist. No.

00585

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 903 Walnut Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Martha Elizabeth Bart				4. DATE OF DEATH Month Day Year Jan. 1, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1880	
9. AGE (In years last birthday) yrs. 78		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Stine			
14. MOTHER'S MAIDEN NAME Cornelia Cornetz				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Address Mrs. Augustine Wickless 903 Walnut St. (Daugh)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardio-vascular renal disease. 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1-2 , 19 52 to 1-1 , 19 59 , that I last saw the deceased alive on 12-29 , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. R. Martin M.D. 35 E Church Frederick Md PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Jan. 5, 1959 22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery 22d. LOCATION (City, town, or county) (State) Uniontown, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr ADDRESS Frederick, Maryland 24a. REC'D BY REGISTRAR DATE JAN 6 1959 24b. REGISTRAR'S SIGNATURE C. B. House							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00586

615

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u>		c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>M. C.</u> Last <u>Beachley</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1876</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William McBride</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ausherman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Franklin E. Beachley, Middletown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Probably Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>with Metastasis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14, 1959</u> , to <u>Jan 16, 1959</u> , that I last saw the deceased alive on <u>Jan 14, 1959</u> , and that death occurred at <u>8:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Elmer Harp</u> M.D.		ADDRESS (Street, city or town, state) <u>Middletown</u> DATE SIGNED <u>1-17-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u>		<u>Middletown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/20/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cemetery, Frederick Co., Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Harp</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

616

CERTIFICATE OF DEATH

Reg. Dist. No.

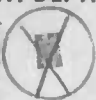
00587

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. LENGTH OF STAY IN 1b 36 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Edna Middle Goldie Last Boller				4. DATE OF DEATH Month January Day 1 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1886		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Collinsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gomer E. Thomas				14. MOTHER'S MAIDEN NAME Mary Greenwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edgar W. Boller Address Thurmont, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cardio-vascular disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22, 1958 , to Jan. 1, 1959 , that I last saw the deceased alive on Dec. 30, 1958 , and that death occurred at 5:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont Md. DATE SIGNED 1/2/59 ACTUAL SIGNATURE M. Franklin Birely M.D. PHYSICIAN'S NAME (Type) M. FRANKLIN BIRELY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence E. Wilson ADDRESS Emmitsburg, Md.				24a. REC'D BY REGISTRAR DATE JAN 5 1959		24b. REGISTRAR'S SIGNATURE Clarence E. Wilson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

item 9 Film 6257 1-19-59 et

00588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			c. LENGTH OF STAY IN 1b <u>7 YRS</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FREDERICK MEMORIAL Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>WILLIE</u> First <u>C</u> Middle <u>BURKE</u> Last			4. DATE OF DEATH <u>JAN</u> Month <u>12</u> Day <u>19</u> Year <u>59</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1884</u>	9. AGE (in years last birthday) <u>44</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MONTROSE W. VA</u>	
13. FATHER'S NAME <u>W. H. BURKE</u>			14. MOTHER'S MAIDEN NAME <u>CHRISTENA MARTIN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>279-10-2932</u>		17. INFORMANT <u>Virginia Johnson</u> Address <u>FREDERICK PT 3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>Arteriovascular disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>4 yrs</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>B. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan 12-1959</u>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MONTROSE Baptist ELKINS</u>	
22d. LOCATION (City, town, or county) <u>W. VA</u>		22e. (State)		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence C. Gault</u>		ADDRESS <u>FREDERICK MD</u>		24a. REC'D BY REGISTRAR <u>Jan 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>					

595

CERTIFICATE OF DEATH

00589

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. STREET ADDRESS Quinn Road							
3. NAME OF DECEASED (Type or print) First BESSIE Middle LOUISE Last BURRIER				4. DATE OF DEATH Month January Day 21 Year 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George E. Hamilton		14. MOTHER'S MAIDEN NAME Margaret Keller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. George A. Burrier, Same as item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.A. of Breast & Prostate							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1958 , to Jan 21, 1959 , that I last saw the deceased alive on Jan 20, 1959 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Lamene Johnny				ADDRESS (Street, city or town, state) East Second Street		DATE SIGNED 1/22/59	
PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1873</u></p>	
<p>5. Place of birth: <u>Arkansas</u></p>		<p>6. Date of death: <u>Jan 20, 1918</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>John J. Brown</u></p>	
<p>11. Signature of undertaker: <u>John J. Brown</u></p>		<p>12. Signature of witness: <u>John J. Brown</u></p>	
<p>13. Signature of coroner: <u>John J. Brown</u></p>		<p>14. Signature of jury: <u>John J. Brown</u></p>	
<p>15. Signature of jury: <u>John J. Brown</u></p>		<p>16. Signature of jury: <u>John J. Brown</u></p>	
<p>17. Signature of jury: <u>John J. Brown</u></p>		<p>18. Signature of jury: <u>John J. Brown</u></p>	
<p>19. Signature of jury: <u>John J. Brown</u></p>		<p>20. Signature of jury: <u>John J. Brown</u></p>	
<p>21. Signature of jury: <u>John J. Brown</u></p>		<p>22. Signature of jury: <u>John J. Brown</u></p>	
<p>23. Signature of jury: <u>John J. Brown</u></p>		<p>24. Signature of jury: <u>John J. Brown</u></p>	
<p>25. Signature of jury: <u>John J. Brown</u></p>		<p>26. Signature of jury: <u>John J. Brown</u></p>	
<p>27. Signature of jury: <u>John J. Brown</u></p>		<p>28. Signature of jury: <u>John J. Brown</u></p>	
<p>29. Signature of jury: <u>John J. Brown</u></p>		<p>30. Signature of jury: <u>John J. Brown</u></p>	
<p>31. Signature of jury: <u>John J. Brown</u></p>		<p>32. Signature of jury: <u>John J. Brown</u></p>	
<p>33. Signature of jury: <u>John J. Brown</u></p>		<p>34. Signature of jury: <u>John J. Brown</u></p>	
<p>35. Signature of jury: <u>John J. Brown</u></p>		<p>36. Signature of jury: <u>John J. Brown</u></p>	
<p>37. Signature of jury: <u>John J. Brown</u></p>		<p>38. Signature of jury: <u>John J. Brown</u></p>	
<p>39. Signature of jury: <u>John J. Brown</u></p>		<p>40. Signature of jury: <u>John J. Brown</u></p>	
<p>41. Signature of jury: <u>John J. Brown</u></p>		<p>42. Signature of jury: <u>John J. Brown</u></p>	
<p>43. Signature of jury: <u>John J. Brown</u></p>		<p>44. Signature of jury: <u>John J. Brown</u></p>	
<p>45. Signature of jury: <u>John J. Brown</u></p>		<p>46. Signature of jury: <u>John J. Brown</u></p>	
<p>47. Signature of jury: <u>John J. Brown</u></p>		<p>48. Signature of jury: <u>John J. Brown</u></p>	
<p>49. Signature of jury: <u>John J. Brown</u></p>		<p>50. Signature of jury: <u>John J. Brown</u></p>	
<p>51. Signature of jury: <u>John J. Brown</u></p>		<p>52. Signature of jury: <u>John J. Brown</u></p>	
<p>53. Signature of jury: <u>John J. Brown</u></p>		<p>54. Signature of jury: <u>John J. Brown</u></p>	
<p>55. Signature of jury: <u>John J. Brown</u></p>		<p>56. Signature of jury: <u>John J. Brown</u></p>	
<p>57. Signature of jury: <u>John J. Brown</u></p>		<p>58. Signature of jury: <u>John J. Brown</u></p>	
<p>59. Signature of jury: <u>John J. Brown</u></p>		<p>60. Signature of jury: <u>John J. Brown</u></p>	
<p>61. Signature of jury: <u>John J. Brown</u></p>		<p>62. Signature of jury: <u>John J. Brown</u></p>	
<p>63. Signature of jury: <u>John J. Brown</u></p>		<p>64. Signature of jury: <u>John J. Brown</u></p>	
<p>65. Signature of jury: <u>John J. Brown</u></p>		<p>66. Signature of jury: <u>John J. Brown</u></p>	
<p>67. Signature of jury: <u>John J. Brown</u></p>		<p>68. Signature of jury: <u>John J. Brown</u></p>	
<p>69. Signature of jury: <u>John J. Brown</u></p>		<p>70. Signature of jury: <u>John J. Brown</u></p>	
<p>71. Signature of jury: <u>John J. Brown</u></p>		<p>72. Signature of jury: <u>John J. Brown</u></p>	
<p>73. Signature of jury: <u>John J. Brown</u></p>		<p>74. Signature of jury: <u>John J. Brown</u></p>	
<p>75. Signature of jury: <u>John J. Brown</u></p>		<p>76. Signature of jury: <u>John J. Brown</u></p>	
<p>77. Signature of jury: <u>John J. Brown</u></p>		<p>78. Signature of jury: <u>John J. Brown</u></p>	
<p>79. Signature of jury: <u>John J. Brown</u></p>		<p>80. Signature of jury: <u>John J. Brown</u></p>	
<p>81. Signature of jury: <u>John J. Brown</u></p>		<p>82. Signature of jury: <u>John J. Brown</u></p>	
<p>83. Signature of jury: <u>John J. Brown</u></p>		<p>84. Signature of jury: <u>John J. Brown</u></p>	
<p>85. Signature of jury: <u>John J. Brown</u></p>		<p>86. Signature of jury: <u>John J. Brown</u></p>	
<p>87. Signature of jury: <u>John J. Brown</u></p>		<p>88. Signature of jury: <u>John J. Brown</u></p>	
<p>89. Signature of jury: <u>John J. Brown</u></p>		<p>90. Signature of jury: <u>John J. Brown</u></p>	
<p>91. Signature of jury: <u>John J. Brown</u></p>		<p>92. Signature of jury: <u>John J. Brown</u></p>	
<p>93. Signature of jury: <u>John J. Brown</u></p>		<p>94. Signature of jury: <u>John J. Brown</u></p>	
<p>95. Signature of jury: <u>John J. Brown</u></p>		<p>96. Signature of jury: <u>John J. Brown</u></p>	
<p>97. Signature of jury: <u>John J. Brown</u></p>		<p>98. Signature of jury: <u>John J. Brown</u></p>	
<p>99. Signature of jury: <u>John J. Brown</u></p>		<p>100. Signature of jury: <u>John J. Brown</u></p>	

617

Item 1 Film G238 2-2-59 et

CERTIFICATE OF DEATH

00590

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girdletree	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Ana Callahan		4. DATE OF DEATH Month Day Year January 25 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Griffin		14. MOTHER'S MAIDEN NAME Mary Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Richard A. Hauver		Address Lantz, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyonephritis 3 mo.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 11-30-58 , 19____, to 1-25-59 , 19____, that I last saw the deceased alive on 1-23-59 , 19____, and that death occurred at 6:50P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 1-25-59					
ACTUAL SIGNATURE Charles F. Hess		M.D. Smithsburg, Md. 1-25-59			
PHYSICIAN'S NAME (Type) Dr. Charles F. Hess					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-28-59	22c. NAME OF CEMETERY OR CREMATORY Beth-Eden Cemetery	22d. LOCATION (City, town, or county) Worcester Girdletree, Maryland-Worcester		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Prattville

Maryland

Oxville

1 yr.

Girdlestone

Clara Ann Callahan

January 25, 1929

Female

White

X

June 12, 1883

Housewife

San Jose

Maryland

U.S.A.

Thomas Griffin

Mary Richardson

No

None

Mrs. Richard A. Haver, Lantz, Md.

Dr. Charles Hess

1-1-29

Bethel-Cemetery

Girdlestone, Maryland-Jones

Raymond L. Greener

Thurmont, Md.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Co.			c. LENGTH OF STAY IN 1b Adamstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital D.O.A.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Felicia Middle Doreen Last Carroll			4. DATE OF DEATH Month January Day 30 Year 1959		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1958		9. AGE (In years last birthday) yrs. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick
					12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Cornelia Carroll		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT Cornelia Carroll Adamstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Viral Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Adamstown	(County) Frederick	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James B. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 31, 1959	
EXAMINER'S NAME (Type) James B. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-1-59	22c. NAME OF CEMETERY OR CREMATORY Hopehill	22d. LOCATION (City, town, or county) (State) Hopehill, Frederick Md		
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hick			24a. REC'D BY REGISTRAR 24 W - All Saints		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00592

Reg. Dist. No.

597

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. STREET ADDRESS Church Hill			
3. NAME OF DECEASED (Type or print) First GERALD Middle ARTHUR Last COOK				4. DATE OF DEATH Month January Day 23 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 May 1953		9. AGE (In years last birthday) 5 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur H. Cook				14. MOTHER'S MAIDEN NAME Nellie Elizabeth Pate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Arthur H. Cook (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis with Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstruction DUE TO (c) Caused by Merckels Diverticulum							INTERVAL BETWEEN ONSET AND DEATH 72 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		24 Jan 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Residence		Occupation		Date of Death	
Cause of Death		Manner of Death		Place of Death	
Physician's Signature		Medical Examiner's Signature		Date of Examination	
Hospital or Institution		City		County	
State		Zip		Telephone	
Burial or Disposition		Funeral Home		Cemetery	
Coroner's Office		Judge's Office		Notary Public	
Witnesses		Medical Examiner's Office		Department of Health	
Remarks		Additional Information		Comments	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		c. LENGTH OF STAY IN 1b 4yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenmerrie Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Thomas Last Cubitt		4. DATE OF DEATH Month 1 Day 23 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George W. Cubitt		14. MOTHER'S MAIDEN NAME Mary Monred	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Roy Bodmer		Address Beallsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardeo Vacular Disease DUE TO (c) Artero sclerosis Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 8 a. m. 1 - 23 - 59 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas Sr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas Sr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-26-59	22c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVER	22d. LOCATION (City, town, or county) (State) FREDERICK MD.
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton		24a. REC'D BY REGISTRAR Arthur L. Kneale	
ADDRESS Barnesville, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale	
DATE JAN 27 '59			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
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OFFICE OF THE REGISTRAR
ALBANY, N. Y.

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
CAUSE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		DATE OF BURIAL	
PLACE OF BURIAL		NAME OF MINISTER	
NAME OF WITNESS		SIGNATURE OF REGISTRAR	
DATE OF ENTRY		OFFICE OF THE REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

598

CERTIFICATE OF DEATH

00594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Magnolia Avenue		e. STREET ADDRESS 400 Magnolia Avenue	
3. NAME OF DECEASED (Type or print) First FRANCES Middle MARGARET Last CUTSAIL		4. DATE OF DEATH Month January Day 5 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James T. Boyer		14. MOTHER'S MAIDEN NAME Clara A. Summers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-1485A	
17. INFORMANT Mr. Roy C. Cutsail--Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter-capillary glomerular sclerosis 260X DUE TO (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 year 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1946 to Jan 5, 1959 , that I last saw the deceased alive on Jan 4, 1959 , and that death occurred at 6:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas Jr.		ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 1/7/59	
PHYSICIAN'S NAME (Type) Dr. Bernard O. Thomas		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etehison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bartonsville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 6				d. STREET ADDRESS Route 6			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Alfred Last Davis				4. DATE OF DEATH Month 1 Day 31 Year 19 59			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22 1899		9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Utilities -- Civil Service		10b. KIND OF BUSINESS OR INDUSTRY Frederick, Co. Md.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Davis				14. MOTHER'S MAIDEN NAME Alice Sewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-4531		17. INFORMANT Address Gladys Davis Rt. 6 Bartonsville Fred. Co. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1 , 19 58 , to Jan. 31 , 19 59 , that I last saw the deceased alive on Jan. 30 , 19 59 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE B.O. Thomas Jr.				ADDRESS (Street, city or town, state) Frederick, Md.			
DATE SIGNED Feb. 2, 1959							
PHYSICIAN'S NAME (Type) B.O. Thomas Jr.		Professional Building Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-59		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III				ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR DATE FEB 4 '59	
				24b. REGISTRAR'S SIGNATURE Charles E. Hicks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00596

Reg. Dist. No.

620

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Fredrick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thermont</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Appolds Church Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Oliver Diehl</u>		4. DATE OF DEATH Month Day Year <u>January 1 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William O Diehl Sr</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-3502</u>	
17. INFORMANT Address <u>Mrs W.O Diehl Thermont Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed right chest</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>823X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car drove into culvert</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour o. m. 11 1959</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Explan road</u>	20f. (City or town) (County) (State) <u>Thermont Fredrick Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Koenig</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	
ADDRESS <u>Hagerstown Md</u>		DATE <u>JAN 5 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

621
CERTIFICATE OF DEATH

Reg. Dist. No.

00597

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Woodsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First <u>CORNELIUS</u> Middle <u>EYLER</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lime plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel J. Eyer</u>		14. MOTHER'S MAIDEN NAME <u>Sager</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war of dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Earl E. Eyer, Woodsboro, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocardial degeneration</u> (c) <u>Chronic myocardial degeneration</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>58</u> to <u>Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 19</u> , 19 <u>59</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Messler</u> M.D.		DATE SIGNED <u>Jan 23 1959</u>	
PHYSICIAN'S NAME (Type) <u>J. H. MESSLETT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		22d. LOCATION (City, town, or county) (State) <u>W. Woodsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.O. Barton, Walkersville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

622

CERTIFICATE OF DEATH

00598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg, Md.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert David Eyler				4. DATE OF DEATH Month January Day 13 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1889	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Robert Eyler			
14. MOTHER'S MAIDEN NAME Catherine Rosensteel				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 218-24-1818				17. INFORMANT Mamie Eyler Address Emmitsburg, R.D. 1 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Coronary insufficiency						INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct 5 , 19 54 , to Jan 13 , 19 59 , that I last saw the deceased alive on Jan 3 , 19 59 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles R Williams M.D.				ADDRESS (Street, city or town, state) Emmitsburg Md DATE SIGNED Jan 14, 1959			
PHYSICIAN'S NAME (Type) Charles R W. Williams							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson				ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

623

CERTIFICATE OF DEATH

Reg. Dist. No. 139

00599

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wesley Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 798 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington			
3. NAME OF DECEASED (Type or print) First Francis Middle Flynn Last Flynn				4. DATE OF DEATH Month Jan. Day 8 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1884		9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael X. Flynn				14. MOTHER'S MAIDEN NAME Annie Carney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 236-03-2590		17. INFORMANT Address Patient and Hospital Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Cardio respiratory failure. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Pulmonary tuberculosis. DUE TO (c) 3. Pneumonoconiosis.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1, 19 56 , to Jan. 8, 19 59 , that I last saw the deceased alive on Jan. 8, 19 59 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE T. F. Vestal				ADDRESS (Street, city or town, state) Cullen, Md.		DATE SIGNED 1/9/59	
PHYSICIAN'S NAME (Type) T. F. Vestal, M.D., Superintendent, Victor Cullen State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/59		22c. NAME OF CEMETERY OR CREMATORY St. Peter's		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pray				ADDRESS Thurman Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1922

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX Male		AGE 45	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Farmer"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1922"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]		NAME OF FUNERAL HOME [Faint text, possibly "The Standard Funeral Home"]		NAME OF BURIAL PLACE [Faint text, possibly "Greenwood Cemetery"]	
NAME OF NEXT OF KIN [Faint text, possibly "Mrs. J. H. Smith"]		NAME OF MINISTER [Faint text, possibly "Rev. W. B. Jones"]		NAME OF CHURCH [Faint text, possibly "St. Paul's Episcopal Church"]	
NAME OF CORONER [Faint text, possibly "John A. Brown"]		NAME OF JURY [Faint text, possibly "George W. White"]		NAME OF JURY [Faint text, possibly "Robert L. Green"]	
NAME OF JURY [Faint text, possibly "Thomas M. Black"]		NAME OF JURY [Faint text, possibly "Charles E. Gray"]		NAME OF JURY [Faint text, possibly "William F. Hall"]	
NAME OF JURY [Faint text, possibly "Edward G. King"]		NAME OF JURY [Faint text, possibly "Frank H. Lee"]		NAME OF JURY [Faint text, possibly "Harold I. Miller"]	
NAME OF JURY [Faint text, possibly "Isaac J. Moore"]		NAME OF JURY [Faint text, possibly "Jacob K. Nelson"]		NAME OF JURY [Faint text, possibly "Lester L. Olsen"]	
NAME OF JURY [Faint text, possibly "Milton M. Parker"]		NAME OF JURY [Faint text, possibly "Norman N. Quinn"]		NAME OF JURY [Faint text, possibly "Oliver O. Reed"]	
NAME OF JURY [Faint text, possibly "Philip P. Scott"]		NAME OF JURY [Faint text, possibly "Richard R. Taylor"]		NAME OF JURY [Faint text, possibly "Samuel S. Vance"]	
NAME OF JURY [Faint text, possibly "Theodore T. White"]		NAME OF JURY [Faint text, possibly "Ulysses U. Young"]		NAME OF JURY [Faint text, possibly "Vernon V. Ziegler"]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

624 Items 9 Film 6238 1-28-59 et

Reg. Dist. No.

006600

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2 c. LENGTH OF STAY IN 1b 2 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Augusta c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro d. STREET ADDRESS 415 Crompton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LESLIE Middle FRED Last FOLTZ		4. DATE OF DEATH Month January Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Aug 1902 1892 66/58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of Log Mill		10b. KIND OF BUSINESS OR INDUSTRY Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME J. W. Foltz		14. MOTHER'S MAIDEN NAME Zella Alshire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. L. F. Foltz, Waynesboro, Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Old Healed Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH Instant 3 Yrs-Plus Years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas, M. D.		DATE SIGNED 21 Jan 1959	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-21-59	
22c. NAME OF CEMETERY OR CREMATORY Waynesboro, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24. REC'D BY REGISTRAR JAN 23 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		24c. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
J. W. Jones		45		Male		White		1945		Home	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
123 Main St.		Teacher		High School		Married		Roman Catholic		Heart Disease	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF FATHER		NAME OF MOTHER	
1900		Maryland		1920		Mary Jones		John Jones		Mary Jones	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
1945		Baltimore		Smith & Sons		Rev. J. Smith		St. Mary's		Greenwood	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF DENTIST		NAME OF PATHOLOGIST	
1945		Baltimore		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER	
1945		Baltimore		J. W. Jones		J. W. Jones		J. W. Jones		J. W. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

625

CERTIFICATE OF DEATH

Reg. Dist. No.

00601

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville		c. LENGTH OF STAY IN 1b 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Riggs Hospital Ijamsville.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs Agnes Jahn First Middle Last		4. DATE OF DEATH Jan 30 Year 1959 Month Day	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8. 1882.
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired assistant Sup. of Nurses		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Otto George Jahn		14. MOTHER'S MAIDEN NAME Emmarenca Bogelman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 726-05-3631 B	
17. INFORMANT Mrs. Roy H. Walter Address Deer Spring Rd. Braddock Heights, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery Occlusion DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27, 1957 to Jan 30, 1959 , that I last saw the deceased alive on Jan 30, 1959 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Lerner		ADDRESS (Street, city or town, state) Ijamsville Md.	
PHYSICIAN'S NAME (Type) Joseph Lerner M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1, '59	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Gulevich		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	
24a. REC'D BY REGISTRAR Feb 3 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00602

626

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Thurmont				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Robert Bruce Gills				4. DATE OF DEATH January 9 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1908	
				9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutting rm. foreman				10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John B. Gills				14. MOTHER'S MAIDEN NAME Alice M. Dangerfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11				16. SOCIAL SECURITY NO. 214-09-573B		17. INFORMANT Josephine Gills	
						Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Coronary Arteriosclerosis DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH Sudden Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Jan 9 1959, to Jan 9 1959, that I last saw the deceased alive on Jan 9 1959, and that death occurred at 8:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James K. Gray M.D. Thurmont - Md. Jan. 16-59 PHYSICIAN'S NAME (Type) James K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-59		22c. NAME OF CEMETERY OR CREMATORY Creagerstown Cem.		22d. LOCATION (City, town, or county) (State) Creagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

627

CERTIFICATE OF DEATH

00603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle L. Last Gladhill		4. DATE OF DEATH Month 1 Day 16 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stone mason		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Gladhill		14. MOTHER'S MAIDEN NAME Magdalene Kinna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ethel Gladhill, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 1 Day 16 Year 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3, 1959 to Jan 16, 1959 , that I last saw the deceased alive on Jan 16, 1959 , and that death occurred at 5 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Elmer Harp		DATE SIGNED 1-17-59	
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		ADDRESS (Street, city or town, state) Middletown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/19/1959	
22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co.,		24a. REC'D BY REGISTRAR DATE JAN 20 '59	
ADDRESS Middletown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kinna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

599

CERTIFICATE OF DEATH

00604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 1 DAY			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEWIS TOWN							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARA ELSIE Gue				4. DATE OF DEATH Month Day Year JAN 17 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 12-1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN CUTSAIL				14. MOTHER'S MAIDEN NAME LYDIA BRASHEARS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) L (If yes, give war or dates of service) L				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MABEL BECRAFT MTAIRY MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aneurysm of heart DUE TO 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO years (c) years							INTERVAL BETWEEN ONSET AND DEATH 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1, 1958 , to January 7, 1959 , that I last saw the deceased alive on January 7, 1959 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE James B. Thomas M.D.				ADDRESS (Street, city or town, state) Fredrick Md.			
DATE SIGNED 1/7/59							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 10-1958		22c. NAME OF CEMETERY OR CREMATORY MARVIN CHAPEL CEM		22d. LOCATION (City, town, or county) (State) PLANE NO 4 FREDK MD	
23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Falcone ADDRESS New Market Md				24a. REC'D BY REGISTRAR JAN 13 59 DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

628

CERTIFICATE OF DEATH

00605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2				c. LENGTH OF STAY IN 1b 14 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2				d. STREET ADDRESS Near Urbana			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Urbana				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JESSIE Middle MATILDA Last HARGETT				4. DATE OF DEATH Month January Day 19 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Dec 1880	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Eugene A. Johnson				14. MOTHER'S MAIDEN NAME Catherine Shuffler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Albert L. Hargett, RD#4, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinoma originating in colon 153.8 DUE TO Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1950 to Jan 19 , 19 59 , that I last saw the deceased alive on Jan 19 , 19 59 , and that death occurred at 8:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 N. Market St., Frederick, Md. DATE SIGNED 21 Jan 1959 ACTUAL SIGNATURE H. F. Kline PHYSICIAN'S NAME (Type) H. F. Kline, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-22-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) (State) Frederick, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Signature of Physician		10. Signature of Registrar		11. Signature of Informant		12. Date of Entry	
13. Signature of Medical Examiner		14. Signature of Coroner		15. Signature of Jury		16. Signature of Judge	
17. Signature of Health Officer		18. Signature of State Registrar		19. Signature of State Auditor		20. Signature of State Treasurer	
21. Signature of State Comptroller		22. Signature of State Attorney General		23. Signature of State Superintendent of Education		24. Signature of State Board of Health	
25. Signature of State Board of Charities		26. Signature of State Board of Prison Commissioners		27. Signature of State Board of Probation		28. Signature of State Board of Mental Health	
29. Signature of State Board of Alcoholism and Drug Abuse Control		30. Signature of State Board of Social Work		31. Signature of State Board of Nursing		32. Signature of State Board of Optometry	
33. Signature of State Board of Podiatric Medicine		34. Signature of State Board of Veterinary Medicine		35. Signature of State Board of Licensure of Professional Counselors		36. Signature of State Board of Licensure of Professional Social Workers	
37. Signature of State Board of Licensure of Professional Engineers		38. Signature of State Board of Licensure of Professional Architects		39. Signature of State Board of Licensure of Professional Surveyors		40. Signature of State Board of Licensure of Professional Geologists	
41. Signature of State Board of Licensure of Professional Landscapers		42. Signature of State Board of Licensure of Professional Horticulturists		43. Signature of State Board of Licensure of Professional Foresters		44. Signature of State Board of Licensure of Professional Game Warden	
45. Signature of State Board of Licensure of Professional Fish and Game Wardens		46. Signature of State Board of Licensure of Professional Game Warden		47. Signature of State Board of Licensure of Professional Game Warden		48. Signature of State Board of Licensure of Professional Game Warden	
49. Signature of State Board of Licensure of Professional Game Warden		50. Signature of State Board of Licensure of Professional Game Warden		51. Signature of State Board of Licensure of Professional Game Warden		52. Signature of State Board of Licensure of Professional Game Warden	
53. Signature of State Board of Licensure of Professional Game Warden		54. Signature of State Board of Licensure of Professional Game Warden		55. Signature of State Board of Licensure of Professional Game Warden		56. Signature of State Board of Licensure of Professional Game Warden	
57. Signature of State Board of Licensure of Professional Game Warden		58. Signature of State Board of Licensure of Professional Game Warden		59. Signature of State Board of Licensure of Professional Game Warden		60. Signature of State Board of Licensure of Professional Game Warden	
61. Signature of State Board of Licensure of Professional Game Warden		62. Signature of State Board of Licensure of Professional Game Warden		63. Signature of State Board of Licensure of Professional Game Warden		64. Signature of State Board of Licensure of Professional Game Warden	
65. Signature of State Board of Licensure of Professional Game Warden		66. Signature of State Board of Licensure of Professional Game Warden		67. Signature of State Board of Licensure of Professional Game Warden		68. Signature of State Board of Licensure of Professional Game Warden	
69. Signature of State Board of Licensure of Professional Game Warden		70. Signature of State Board of Licensure of Professional Game Warden		71. Signature of State Board of Licensure of Professional Game Warden		72. Signature of State Board of Licensure of Professional Game Warden	
73. Signature of State Board of Licensure of Professional Game Warden		74. Signature of State Board of Licensure of Professional Game Warden		75. Signature of State Board of Licensure of Professional Game Warden		76. Signature of State Board of Licensure of Professional Game Warden	
77. Signature of State Board of Licensure of Professional Game Warden		78. Signature of State Board of Licensure of Professional Game Warden		79. Signature of State Board of Licensure of Professional Game Warden		80. Signature of State Board of Licensure of Professional Game Warden	
81. Signature of State Board of Licensure of Professional Game Warden		82. Signature of State Board of Licensure of Professional Game Warden		83. Signature of State Board of Licensure of Professional Game Warden		84. Signature of State Board of Licensure of Professional Game Warden	
85. Signature of State Board of Licensure of Professional Game Warden		86. Signature of State Board of Licensure of Professional Game Warden		87. Signature of State Board of Licensure of Professional Game Warden		88. Signature of State Board of Licensure of Professional Game Warden	
89. Signature of State Board of Licensure of Professional Game Warden		90. Signature of State Board of Licensure of Professional Game Warden		91. Signature of State Board of Licensure of Professional Game Warden		92. Signature of State Board of Licensure of Professional Game Warden	
93. Signature of State Board of Licensure of Professional Game Warden		94. Signature of State Board of Licensure of Professional Game Warden		95. Signature of State Board of Licensure of Professional Game Warden		96. Signature of State Board of Licensure of Professional Game Warden	
97. Signature of State Board of Licensure of Professional Game Warden		98. Signature of State Board of Licensure of Professional Game Warden		99. Signature of State Board of Licensure of Professional Game Warden		100. Signature of State Board of Licensure of Professional Game Warden	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

600

CERTIFICATE OF DEATH

00606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROY Middle McKINLEY Last HARRIS				4. DATE OF DEATH Month January Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1896	
9. AGE (In years last birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Postmaster		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harris				14. MOTHER'S MAIDEN NAME Lucy Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Nellie A. Harris;				805 Motter Ave. Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Viral Pneumonia DUE TO (c) old Post Myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1, 1958 , to April 15, 1959 , that I last saw the deceased alive on Jan 5, 1959 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 East 2nd St. Frederick, Maryland DATE SIGNED 1/8/59							
ACTUAL SIGNATURE H. L. Fahrney M.D.							
PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				c. LENGTH OF STAY IN 1b 18 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2, Spruce Run Road			
d. STREET ADDRESS Rt. #2, Spruce Run Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle LEE Last HAYS				4. DATE OF DEATH Month January Day 16 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 17, 1881	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7		IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm (Gen.)		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Clay Hays				14. MOTHER'S MAIDEN NAME Susan Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-18-0743		17. INFORMANT Mrs. Pearl Johnson, Myersville, Md. Rt. #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO 5 years. (c)						INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. 19 Day. 19 Year. 19 Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Smithsburg, Md.				20g. (County) Frederick		20h. (State) Md.	
21. I certify that I attended the deceased from 4-17-57 , 19 57 , to 1-16-59 , 19 59 , that I last saw the deceased alive on 1-5-59 , 19 59 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. Hess				ADDRESS (Street, city or town, state) Smithsburg, Md.			
M.D. 1-17-59				DATE SIGNED 1-17-59			
PHYSICIAN'S NAME (Type) Dr. Charles F. Hess				Smithsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Partial		22b. DATE THEREOF Jan. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Mark's Luth.		22d. LOCATION (City, town, or county) (State) Wolfsville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR DATE JAN 19 '59	
24b. REGISTRAR'S SIGNATURE Charles L. Hess							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) 703 Rosemont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIABELL Middle JAMES Last JAMES		4. DATE OF DEATH Month January Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Jan 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank E. Brunner		14. MOTHER'S MAIDEN NAME Susan Stottlemeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT 211 Rockwell Terrace, Mrs. Bernard M. Davis, Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 3-4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 16, 1958 , to Jan 17, 1959 , that I last saw the deceased alive on Jan 16, 1959 , and that death occurred at 1:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V Chase M.D.		DATE SIGNED 19 Jan 1959	
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE AN 20 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

NAME OF DECEASED		FEDERAL ID	
SEX		AGE	
RACE		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
CITY		STATE	
COUNTY		ZIP CODE	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
OCCUPATION		EDUCATION	
RELIGION		MARRIAGE	
CHILDREN		PARENTS	
SIBLINGS		GRANDPARENTS	
AUNT/UNCLES		COUSINS	
Nephews/Nieces		Other Relatives	
Friends		Neighbors	
Community		Other	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

630

CERTIFICATE OF DEATH

00609

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW MARKET</u>		LENGTH OF STAY (In this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW MARKET</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lewis Calvin JAMES JR</u>				<u>JAN 24 1959</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLORED</u>	<u>WIDOWED</u>	<u>SEPT 18-1902</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>				<u>NEW MARKET MD</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>LEWIS C. JAMES SR</u>				<u>MARY SEWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>2</u>		<u>219-079688</u>		<u>SON WILLIAM JAMES NEW MARKET MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
241X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Acute coronary occlusion</u>						<u>Minutes</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<u>10 yrs</u>	
STATING UNDERLYING CAUSE LAST.						<u>15 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/12</u>, 19<u>56</u>, to <u>JAN 24</u>, 19<u>59</u>, that I last saw the deceased alive on <u>Sept 22</u>, 19<u>58</u>, and that death occurred at <u>3 P</u>. M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Ralph S. Middles</u>				<u>M.D. Shopping Center, Frederick, Md</u>		<u>1/26/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN 27-59</u>		<u>SIMPSON'S CHAPEL CEM</u>		<u>NEW MARKET MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 29 '59</u>		<u>Calvin S. James</u>		<u>L. K. Falbomer</u>		<u>New Market MD</u>	

DEC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN IB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Maple Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
3. NAME OF DECEASED (Type or print) First Alice Middle E Last Keller		4. DATE OF DEATH Month 1 Day 9 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Haller		14. MOTHER'S MAIDEN NAME Annie Wrench	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. William R. Nalley, Brunswick, Md.	
17. INFORMANT Mr. William R. Nalley, Brunswick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO Hypertension (c) Yes		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 9, 1959 that I last saw the deceased alive on 12/31/58 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. G. F. Smith		M.D. Brunswick, Md. DATE SIGNED 1/19/59	
PHYSICIAN'S NAME (Type) J. G. F. Smith		Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-1959	
22c. NAME OF CEMETERY OR CREMATORY Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Lute		ADDRESS Brunswick, Maryland	
24a. REG'D BY REGISTRAR JAN 15 59		DATE	
24b. REGISTRAR'S SIGNATURE William R. Nalley			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00611

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b Since 10-15-58	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home			d. STREET ADDRESS 106 West Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HAZEL	First RIDENOUR	Middle KEPLER	4. DATE OF DEATH Month January Day 22 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Aug 1889	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph A. Ridenour			14. MOTHER'S MAIDEN NAME Ida Wise		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Convalescent Home Records (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma trachea 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of M. trach. DUE TO (c) about 2 yrs INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct 15, 1958 to Jan 22, 1959 , that I last saw the deceased alive on January 21, 1959 , and that death occurred at 2:25 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE H. L. Fahrney		M.D. 17 E. Second St.		DATE SIGNED 22 Jan 1959	
PHYSICIAN'S NAME (Type) H. L. Fahrney, M. D.		Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 26 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Thwait					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased _____		Sex _____		Date of Birth _____	
Usual Residence _____		Date of Death _____		Time of Death _____	
Cause of Death _____		Place of Death _____		Signature of Physician _____	
Signature of Registrar _____		Signature of Coroner _____		Signature of Medical Examiner _____	
Date of Registration _____		Date of Coroner's Report _____		Date of Medical Examiner's Report _____	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 602 CERTIFICATE OF DEATH

00612

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 S. Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susie Middle L. Last Kinna		4. DATE OF DEATH Month Jan. Day 8, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 7, 1898 9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matron Md. St. School for the Deaf		10b. KIND OF BUSINESS OR INDUSTRY Philadelphia Penn.	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Harry Fox Gill		14. MOTHER'S MAIDEN NAME Mrs. Alice B. Akers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 201-12-5929	
17. INFORMANT Mrs. Alice B. Akers		Address 1304 N. Market St. Fred.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4.20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Enteritis due to Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			INTERVAL BETWEEN ONSET AND DEATH 1 day 6 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13, 1958 , to Jan 8, 1959 , that I last saw the deceased alive on Dec 16, 1958 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Austin Pearre M.D.		DATE SIGNED Frederick, Md 1/8/59	
PHYSICIAN'S NAME (Type) A. Austin Pearre M.D.		4 East Church Street	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Jan. 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Olvier H. Bair Funeral Home	22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey		24a. REC'D BY REGISTRAR JAN 12 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G241 4-30-59 et

632

CERTIFICATE OF DEATH

00613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick		c. LENGTH OF STAY IN 1b 20 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Brunswick		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION New Addition	
d. STREET ADDRESS New Addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Johanna Last Francis Lamb		4. DATE OF DEATH 1 Month 11 Day 59 Year 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31-1877	
9. AGE (In years birthday) yrs. 81		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Handy man	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Lamb		14. MOTHER'S MAIDEN NAME Louretta Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Rosa Lamb, Brunswick, Maryland	
17. INFORMANT Mrs. Rosa Lamb, Brunswick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1958 to Dec. 24, 1958 , that I last saw the deceased alive on Dec. 24, 1958 , and that death occurred at Jan. 11, 1959 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 S. Maryland Ave. Brunswick, Md. DATE SIGNED Jan. 12, 1959			
ACTUAL SIGNATURE C. T. Byron Kao		M.D. 15 S. Maryland Ave. Brunswick, Md.	
PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D.		DATE SIGNED Jan. 12, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-1959	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. E. Lantz		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR Jan 15 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Johnsville</u>				c. LENGTH OF STAY IN 1b <u>14 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>---</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE SADIE LOOKINGBILL</u>				4. DATE OF DEATH Month Day Year <u>Jan 8 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Draper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Frank Lookingbill, Johnsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-2-</u> , 19 <u>59</u> , to <u>1-8-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-8-</u> , 19 <u>59</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Legg</u>			M.D. <u>Union Bridge</u>		DATE SIGNED <u>1-8-59</u>		
PHYSICIAN'S NAME (Type) <u>Dr. T. H. Legg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bearss Dam</u>		22d. LOCATION (City, town, or county) (State) <u>Johnsville Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>			ADDRESS <u>Walkersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

634

CERTIFICATE OF DEATH

00615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Long Corner 13x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Moxley St.				d. STREET ADDRESS RFD 3, Mt. Airy			
3. NAME OF DECEASED (Type or print) First Laura Middle - Last Molesworth				4. DATE OF DEATH Month Jan. Day 15 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1873	
				9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Randolph Day				14. MOTHER'S MAIDEN NAME Alberta Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Eli T. Molesworth, Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1958 , to Jan 15, 1959 , that I last saw the deceased alive on Jan 15, 1959 , and that death occurred at 11:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE CM Van Pelt				DATE SIGNED 1-17-59			
PHYSICIAN'S NAME (Type) CM Van Pelt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Howard Chapel		22d. LOCATION (City, town, or county) (State) Long Corner, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molesworth				24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00616

Reg. Dist. No.

603

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>Life Frederick Co.</u> <u>X</u> Ijamsville R.F.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Nagle</u>		4. DATE OF DEATH <u>January 21</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick County</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Hilderbrand</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Main</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Frederick Memorial records</u>	
17. INFORMANT <u>Frederick Memorial records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Healed posterior myocardial infarct</u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <u>B.O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>January 21, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 24, '59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Springs Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Daley</u> ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Robert E. Daley</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10

1918

NAME OF DECEASED

Robertson

RESIDENCE

1111 North Street, Baltimore, Md.

DATE OF DEATH

January 21, 1918

AGE

65

SEX

Male

CAUSE OF DEATH

Myocardial infarction

PLACE OF DEATH

Home

DATE OF EXAMINATION

January 21, 1918

SIGNATURE OF EXAMINER

John H. ...

PLACE OF EXAMINATION

Home

DATE OF EXAMINATION

January 21, 1918

SIGNATURE OF EXAMINER

John H. ...

PLACE OF EXAMINATION

Home

DATE OF EXAMINATION

January 21, 1918

SIGNATURE OF EXAMINER

John H. ...

PLACE OF EXAMINATION

Home

DATE OF EXAMINATION

January 21, 1918

SIGNATURE OF EXAMINER

John H. ...

PLACE OF EXAMINATION

Home

DATE OF EXAMINATION

January 21, 1918

SIGNATURE OF EXAMINER

John H. ...

Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

635

Item 9 FilmG237 1-13-59 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hagerstown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hosp.</u>		d. STREET ADDRESS <u>461 Revolution St</u>	
3. NAME OF DECEASED (Type or print) <u>Emerson</u> <u>Warren</u> <u>NIPER</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cheff</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Niper</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Tinklepaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>178-03-1327</u>	
17. INFORMANT <u>Patient (Hospital Chart).</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia with Convulsions</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>Bilateral Hydro-Nephrosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Few Hours.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Far Advanced Pulmonary Tuberculosis</u> <u>002 X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/23/1958</u> , 19 <u>58</u> to <u>1/4/1959</u> , that I last saw the deceased alive on <u>1/4/1959</u> , 19 <u>59</u> , and that death occurred at <u>8:50 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cullen, Md.</u> DATE SIGNED <u>1/4/59.</u>			
ACTUAL SIGNATURE <u>T. F. Vestal</u>		M.D. <u>Cullen, Md.</u>	
PHYSICIAN'S NAME (Type) <u>T. F. Vestal, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>✓</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. S. Grease</u>		ADDRESS <u>John Thorman</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH ONE 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF CONSTABLE</p>		<p>20. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>21. SIGNATURE OF VOTING CLERK</p>		<p>22. SIGNATURE OF TOWN CLERK</p>		<p>23. SIGNATURE OF COUNTY CLERK</p>		<p>24. SIGNATURE OF STATE CLERK</p>	
<p>25. SIGNATURE OF DEPARTMENT CLERK</p>		<p>26. SIGNATURE OF HEALTH COMMISSIONER</p>		<p>27. SIGNATURE OF ATTORNEY GENERAL</p>		<p>28. SIGNATURE OF JUDGE OF PROBATE</p>	
<p>29. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>30. SIGNATURE OF DECEASED'S NEXT OF KIN</p>		<p>31. SIGNATURE OF DECEASED'S EXECUTOR</p>		<p>32. SIGNATURE OF DECEASED'S ADMINISTRATOR</p>	
<p>33. SIGNATURE OF DECEASED'S GUARDIAN</p>		<p>34. SIGNATURE OF DECEASED'S CURATOR</p>		<p>35. SIGNATURE OF DECEASED'S COMMITTEE</p>		<p>36. SIGNATURE OF DECEASED'S TRUSTEE</p>	
<p>37. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>38. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>39. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>40. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>41. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>42. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>43. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>44. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>45. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>46. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>47. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>48. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>49. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>50. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>51. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>52. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>53. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>54. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>55. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>56. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>57. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>58. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>59. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>60. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>61. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>62. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>63. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>64. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>65. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>66. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>67. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>68. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>69. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>70. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>71. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>72. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>73. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>74. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>75. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>76. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>77. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>78. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>79. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>80. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>81. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>82. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>83. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>84. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>85. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>86. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>87. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>88. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>89. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>90. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>91. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>92. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>93. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>94. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>95. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>96. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	
<p>97. SIGNATURE OF DECEASED'S FIDELITY BOND AGENT</p>		<p>98. SIGNATURE OF DECEASED'S FIDELITY BOND SURETY</p>		<p>99. SIGNATURE OF DECEASED'S FIDELITY BOND UNDERWRITER</p>		<p>100. SIGNATURE OF DECEASED'S FIDELITY BOND BROKER</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH ONE 18

636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. LENGTH OF STAY IN 1b <u>381 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Leon</u> Middle <u>Noose</u> Last		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph L. Noose</u>		14. MOTHER'S MAIDEN NAME <u>Roscoe Virginia Bagent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-12-1743</u>	
17. INFORMANT <u>Records of Victor Cullen Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>58</u> , to <u>1/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>59</u> , and that death occurred at <u>1:45</u> AM, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>T. F. Vestal</u>		ADDRESS (Street, city or town, state) <u>Cullen, Md.</u>	
DATE SIGNED <u>1/27/59</u>			
PHYSICIAN'S NAME (Type) <u>T. F. Vestal</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Loudoun County, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Brager</u>		ADDRESS <u>Thermont, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAIL BOARD

APR 1944

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		DATE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF JAILER	
SIGNATURE OF WITNESSES		SIGNATURE OF JAIL BOARD	
DATE OF CERTIFICATE		JAIL BOARD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00619

637

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont				c. LENGTH OF STAY IN 1b Lifetime			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--- Thurmont				d. STREET ADDRESS Rural Route #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home-Thurmont				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Minnie Florence Nunemaker				4. DATE OF DEATH January 24 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Shuff				14. MOTHER'S MAIDEN NAME Matilda Mumford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT John Nunemaker		Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 23 , 19 59 to Jan 24 , 19 59 , that I last saw the deceased alive on Jan 23 , 19 59 , and that death occurred at 4 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont Md. DATE SIGNED Jan 24-59							
ACTUAL SIGNATURE James K. Gray		M.D. Thurmont Md.					
PHYSICIAN'S NAME (Type) Dr. James K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		22d. LOCATION (City, town, or county) (State) Lewistown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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Wanda Pierce, Publisher

Female White

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A. E. H.

Robert F. Chubb

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Journal of Management Education

Dr. James E. Gray

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CERTIFICATE OF DEATH

00629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u> 01X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>118 Winchester Road</u>	
3. NAME OF DECEASED (Type or print) <u>Guy</u> First <u>J.</u> Middle <u>O'Hara</u> Last <u>St.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry cleaning</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaning</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph O'Hara</u>		14. MOTHER'S MAIDEN NAME <u>Bell Click</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>236-03-2624</u>	
17. INFORMANT <u>Records of Victor Cullen State Hospital</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> <u>002X</u> DUE TO <u>Advanced Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/24</u> 19 <u>58</u> to <u>1/27</u> 19 <u>59</u> , that I last saw the deceased alive on <u>1/27</u> 19 <u>59</u> , and that death occurred at <u>6:30 P.</u> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Cullen, Md.</u> DATE SIGNED <u>1/27/59</u>	
ACTUAL SIGNATURE <u>T.F. Vestal</u>		M.D. <u></u>	
PHYSICIAN'S NAME (Type) <u>T. F. Vestal</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davis Mem. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scarpelli Funeral Home</u> ADDRESS <u>Cumberland Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WIMBROD

<p>1. Name of deceased: <u>WIMBROD</u></p>		<p>2. Date of death: <u>1944</u></p>	
<p>3. Place of death: <u>WIMBROD</u></p>		<p>4. Cause of death: <u>WIMBROD</u></p>	
<p>5. Age at death: <u>WIMBROD</u></p>		<p>6. Sex: <u>WIMBROD</u></p>	
<p>7. Race: <u>WIMBROD</u></p>		<p>8. Marital status: <u>WIMBROD</u></p>	
<p>9. Occupation: <u>WIMBROD</u></p>		<p>10. Education: <u>WIMBROD</u></p>	
<p>11. Date of birth: <u>WIMBROD</u></p>		<p>12. Place of birth: <u>WIMBROD</u></p>	
<p>13. Date of death: <u>WIMBROD</u></p>		<p>14. Place of death: <u>WIMBROD</u></p>	
<p>15. Date of death: <u>WIMBROD</u></p>		<p>16. Place of death: <u>WIMBROD</u></p>	
<p>17. Date of death: <u>WIMBROD</u></p>		<p>18. Place of death: <u>WIMBROD</u></p>	
<p>19. Date of death: <u>WIMBROD</u></p>		<p>20. Place of death: <u>WIMBROD</u></p>	
<p>21. Date of death: <u>WIMBROD</u></p>		<p>22. Place of death: <u>WIMBROD</u></p>	
<p>23. Date of death: <u>WIMBROD</u></p>		<p>24. Place of death: <u>WIMBROD</u></p>	
<p>25. Date of death: <u>WIMBROD</u></p>		<p>26. Place of death: <u>WIMBROD</u></p>	
<p>27. Date of death: <u>WIMBROD</u></p>		<p>28. Place of death: <u>WIMBROD</u></p>	
<p>29. Date of death: <u>WIMBROD</u></p>		<p>30. Place of death: <u>WIMBROD</u></p>	
<p>31. Date of death: <u>WIMBROD</u></p>		<p>32. Place of death: <u>WIMBROD</u></p>	
<p>33. Date of death: <u>WIMBROD</u></p>		<p>34. Place of death: <u>WIMBROD</u></p>	
<p>35. Date of death: <u>WIMBROD</u></p>		<p>36. Place of death: <u>WIMBROD</u></p>	
<p>37. Date of death: <u>WIMBROD</u></p>		<p>38. Place of death: <u>WIMBROD</u></p>	
<p>39. Date of death: <u>WIMBROD</u></p>		<p>40. Place of death: <u>WIMBROD</u></p>	
<p>41. Date of death: <u>WIMBROD</u></p>		<p>42. Place of death: <u>WIMBROD</u></p>	
<p>43. Date of death: <u>WIMBROD</u></p>		<p>44. Place of death: <u>WIMBROD</u></p>	
<p>45. Date of death: <u>WIMBROD</u></p>		<p>46. Place of death: <u>WIMBROD</u></p>	
<p>47. Date of death: <u>WIMBROD</u></p>		<p>48. Place of death: <u>WIMBROD</u></p>	
<p>49. Date of death: <u>WIMBROD</u></p>		<p>50. Place of death: <u>WIMBROD</u></p>	
<p>51. Date of death: <u>WIMBROD</u></p>		<p>52. Place of death: <u>WIMBROD</u></p>	
<p>53. Date of death: <u>WIMBROD</u></p>		<p>54. Place of death: <u>WIMBROD</u></p>	
<p>55. Date of death: <u>WIMBROD</u></p>		<p>56. Place of death: <u>WIMBROD</u></p>	
<p>57. Date of death: <u>WIMBROD</u></p>		<p>58. Place of death: <u>WIMBROD</u></p>	
<p>59. Date of death: <u>WIMBROD</u></p>		<p>60. Place of death: <u>WIMBROD</u></p>	
<p>61. Date of death: <u>WIMBROD</u></p>		<p>62. Place of death: <u>WIMBROD</u></p>	
<p>63. Date of death: <u>WIMBROD</u></p>		<p>64. Place of death: <u>WIMBROD</u></p>	
<p>65. Date of death: <u>WIMBROD</u></p>		<p>66. Place of death: <u>WIMBROD</u></p>	
<p>67. Date of death: <u>WIMBROD</u></p>		<p>68. Place of death: <u>WIMBROD</u></p>	
<p>69. Date of death: <u>WIMBROD</u></p>		<p>70. Place of death: <u>WIMBROD</u></p>	
<p>71. Date of death: <u>WIMBROD</u></p>		<p>72. Place of death: <u>WIMBROD</u></p>	
<p>73. Date of death: <u>WIMBROD</u></p>		<p>74. Place of death: <u>WIMBROD</u></p>	
<p>75. Date of death: <u>WIMBROD</u></p>		<p>76. Place of death: <u>WIMBROD</u></p>	
<p>77. Date of death: <u>WIMBROD</u></p>		<p>78. Place of death: <u>WIMBROD</u></p>	
<p>79. Date of death: <u>WIMBROD</u></p>		<p>80. Place of death: <u>WIMBROD</u></p>	
<p>81. Date of death: <u>WIMBROD</u></p>		<p>82. Place of death: <u>WIMBROD</u></p>	
<p>83. Date of death: <u>WIMBROD</u></p>		<p>84. Place of death: <u>WIMBROD</u></p>	
<p>85. Date of death: <u>WIMBROD</u></p>		<p>86. Place of death: <u>WIMBROD</u></p>	
<p>87. Date of death: <u>WIMBROD</u></p>		<p>88. Place of death: <u>WIMBROD</u></p>	
<p>89. Date of death: <u>WIMBROD</u></p>		<p>90. Place of death: <u>WIMBROD</u></p>	
<p>91. Date of death: <u>WIMBROD</u></p>		<p>92. Place of death: <u>WIMBROD</u></p>	
<p>93. Date of death: <u>WIMBROD</u></p>		<p>94. Place of death: <u>WIMBROD</u></p>	
<p>95. Date of death: <u>WIMBROD</u></p>		<p>96. Place of death: <u>WIMBROD</u></p>	
<p>97. Date of death: <u>WIMBROD</u></p>		<p>98. Place of death: <u>WIMBROD</u></p>	
<p>99. Date of death: <u>WIMBROD</u></p>		<p>100. Place of death: <u>WIMBROD</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

604

CERTIFICATE OF DEATH

Reg. Dist. No.

00621

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 1406 N. Market Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cleveland W. Repp				4. DATE OF DEATH January 15 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1883	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel S. Repp		14. MOTHER'S MAIDEN NAME Lavenia Diehl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-34-3795		17. INFORMANT Mrs. Mabel Repp, Frederick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Arteriosclerosis Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-2 , 19 56 , to 1-15 , 19 59 , that I last saw the deceased alive on 1-15 , 19 59 , and that death occurred at 5:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4W 3 rd St DATE SIGNED 1-16-59							
ACTUAL SIGNATURE Thomas E. Stone M.D.				PHYSICIAN'S NAME (Type) Thomas E. Stone			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Middleburg Cemetery		22d. LOCATION (City, town, or county) (State) Middleburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss ADDRESS C.O. Fuss & Son, Taneytown, Maryland				24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

639

CERTIFICATE OF DEATH

Reg. Dist. No.

00622

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rocky Ridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Rocky Ridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.</u>		d. STREET ADDRESS <u>R.D.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Laura</u> Last <u>Riffle</u>		4. DATE OF DEATH <u>January</u> Month <u>December</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1867</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Maranda Slaughenhaupt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. James Saylor</u>		Address <u>Rocky Ridge, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1959</u> to <u>Jan 31, 1959</u> , that I last saw the deceased alive on <u>Jan 30, 1959</u> , and that death occurred at <u>6:59</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W R Cadle</u>		M.D. <u>Emmitsburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. R. Cadle</u>		<u>Emmitsburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elias Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson</u>		ADDRESS <u>Emmitsburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

00623

Reg. Dist. No.

640

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At his own home		d. STREET ADDRESS Walnut Street	
3. NAME OF DECEASED (Type or print) Charles First Leo Middle Schildt Last		4. DATE OF DEATH Month January 26 Day 19 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1874
9. AGE (In years and birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Dept.		10b. KIND OF BUSINESS OR INDUSTRY WMRR	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Schildt		14. MOTHER'S MAIDEN NAME Elizabeth Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-8742	
17. INFORMANT Mrs. Ida F. Schildt		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 22, 1958 , to Jan 24, 1959 , that I last saw the deceased alive on Jan 24, 1959 , and that death occurred at 4 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Thurmont - Md. DATE SIGNED		ACTUAL SIGNATURE James T. Gray M.D.	
PHYSICIAN'S NAME (Type) Dr. James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-59	
22c. NAME OF CEMETERY OR CREMATORY United Brethern Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE 2 8 '59		24b. REGISTRAR'S SIGNATURE James T. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

JAN 28 '59

Raymond E. Greaser, Townsend, Md.

Interred in the United Brothers Cemetery, Townsend, Maryland

Dr. James K. Gray

Form with multiple sections for recording details, including a large section for a photograph and various fields for text entry.

No. 218-07-8745 Mrs. Ida E. Schlicht, Townsend, Md.

David Schlicht

Elizabeth Jones

Maintenance Dept.

WHR

Penna.

Male

White

June 6, 1874

60

Charles

Lee

Schlicht

January 26

50

Wainut Street

20 yrs.

Townsend

Frederick

Maryland

Frederick

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 15 Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CAM Middle FOREST Last SCOTT			4. DATE OF DEATH Month January Day 22 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 May 1891	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME James Scott			14. MOTHER'S MAIDEN NAME Nancy Blake		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-22-1146		17. INFORMANT Alfred Scott, Adamstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED LIVER WITH HEMORRHAGE DUE TO (b) CRUSHED CHEST DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 15 Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head-on Automobile Accident			
20c. TIME OF INJURY Month, Day, Year 6:30 XXXX 1-22, 1959 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Highway		20f. (City or town) (County) (State) Rt. 355-Nr Urbana-Fred'k, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>B. O. Thomas</i>			DATE SIGNED 23 Jan 1959		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/24/59	22c. NAME OF CEMETERY OR CREMATORY Heard Cemetery W. Virginia		22d. LOCATION (City, town, or county) (State) W. Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. B. E. Thomas</i>		ADDRESS Frederick		24a. REC'D BY REGISTRAR JAN 26 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00625

606

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boys 15 x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mrs. Wm. Fred Selby		4. DATE OF DEATH Jan 12 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 2-1898
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Snyder		14. MOTHER'S MAIDEN NAME Florence Walter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr Brice Selby, Boys, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart failure, acute DUE TO (b) Arteriosclerotic Heart disease DUE TO (c) 5 years +		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Diabetes mellitus 2) Cerebral infarction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28, 1958 , to Jan 12, 1959 , that I last saw the deceased alive on Jan 12, 1959 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearse M.D. Frederick, Md.		DATE SIGNED 1/13/59	
PHYSICIAN'S NAME (Type) A. A. Pearse			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/59	
22c. NAME OF CEMETERY OR CREMATORY St. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton - Barneville Md.		24a. REC'D BY REGISTRAR Charles E. Hays	
24b. REGISTRAR'S SIGNATURE		DATE JAN 16 '59	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00626

607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 65 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 201 West Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle FLORENCE Last SHULTZ		4. DATE OF DEATH Month January Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Oct 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Osborn C. Crist		14. MOTHER'S MAIDEN NAME Ida J. Horner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles H. Shultz (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous enteritis 011X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1 , 19 59 , to Jan 30 , 19 59 , that I last saw the deceased alive on Jan 29 , 19 59 , and that death occurred at 11:15 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D.		ADDRESS (Street, city or town, state) 228 N. Market St., DATE SIGNED 2 Feb 1959	
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 3 '59	
24b. REGISTRAR'S SIGNATURE Charles L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

641

CERTIFICATE OF DEATH

Reg. Dist. No.

00627

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VA. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADDOCK HEIGHTS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHARLESTON 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VINDOBONA NURSING HOME		d. STREET ADDRESS JEFFERSON BLVD.	
3. NAME OF DECEASED (Type or print) First BESSIE Middle SKLAR Last		4. DATE OF DEATH Month JANUARY Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1894 (64) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home-making	11. BIRTHPLACE (State or foreign country) Russia.
13. FATHER'S NAME Solomon Liss		14. MOTHER'S MAIDEN NAME Sarah Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Non..	17. INFORMANT Ethel Sklar, Address Kansas City Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1930 glioma of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/15, 1958 , to 1/16, 1959 , that I last saw the deceased alive on 1/15, 1959 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228, N. Market St. Frederick, Md. DATE SIGNED 1/17/59			
ACTUAL SIGNATURE L. R. Schoolman M.D.			
PHYSICIAN'S NAME (Type) L. R. Schoolman, MD.			
22a. BURIAL, CREMATION, REMOVAL (Type)	22b. DATE THEREOF Jan. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY HAR JEHUDA Cemetery	22d. LOCATION (City, town, or county) (State) PHILADELPHIA, Pennsylvania.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT E. DAILEY & SON, FREDERICK, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Harris

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00628

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN TB Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DORA Middle VIRGINIA Last SOUDER				4. DATE OF DEATH Month January Day 6 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Burr Titus				14. MOTHER'S MAIDEN NAME Virginia Hauser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dorothy S. Beatty; Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 1 day 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 25, 1958 to Jan 6, 1959 , that I last saw the deceased alive on Dec 28, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearre M.D.				ADDRESS (Street, city or town, state) 4 East Church St. DATE SIGNED 1/8/59			
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/59		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son; Frederick, Maryland				24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

1907

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1907	
AGE		SEX	
65		Male	
RACE		OCCUPATION	
White		Farmer	
BIRTHPLACE		PLACE OF DEATH	
Maryland		Maryland	
MANNER OF DEATH		CAUSE OF DEATH	
Natural		Heart Disease	
DISEASE OR INJURY		PERIOD OF ILLNESS	
Heart Disease		Several Months	
DATE OF BIRTH		DATE OF INTERMENT	
JANUARY 10, 1907		JANUARY 10, 1907	
PLACE OF INTERMENT		NAME OF MINISTER	
St. Paul's Church		Rev. J. H. Harris	
NAME OF WITNESSES		NAME OF REGISTRAR	
J. H. Harris, J. H. Harris		J. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

643

CERTIFICATE OF DEATH

00529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/ d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Hamilton Last Springer		4. DATE OF DEATH Month January Day 24 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farms	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Springer		14. MOTHER'S MAIDEN NAME Fannie Lantz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-14-2297A	
17. INFORMANT Minerva Springer		Address Thurmont RD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1948 , to Jan. 24, 1959 , that I last saw the deceased alive on Jan. 24, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely		ADDRESS (Street, city or town, state) Thurmont Md.	
DATE SIGNED 1/26/59			
PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 1-27-59	
22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE JAN 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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Name of Deceased William Hamilton Springer		Sex Male		Age 50 yrs.		Race White		Date of Birth July 12, 1882		Place of Birth U.S.A.	
Cause of Death Heart Disease		Manner of Death Natural		Occupation Farmer		Usual Residence Springer, Maryland		Date of Death January 24, 1933		Place of Death Springer, Maryland	
Physician's Signature Dr. H. Franklin Bixby		Signature of Informant George Springer		Relationship of Informant Brother		Signature of Informant George Springer		Signature of Informant George Springer		Signature of Informant George Springer	
Hospital United Presbyterian Hosp.		City Baltimore, Md.		State Md.		County Baltimore		District 1-22-32		Registration Number 1-22-32	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

00634

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Walkersville</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Walkersville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ZOA</u> Middle <u>ELLEN</u> Last <u>STALEY</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>22</u> Year <u>19 59</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30, 1893</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Mercer</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia Poole</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Raymond Staley, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V.D.</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dilated mitral valve</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 Jan., 19 59</u> , to <u>22 Jan., 19 59</u> , that I last saw the deceased alive on <u>22 Jan., 19 59</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D. <u>Walkersville, Md.</u>						DATE SIGNED <u>1/23/59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Jan. 25, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Walkersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton, Walkersville, Md.</u> ADDRESS						24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00631

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adamstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Adamstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>SHARON JUNE STINE</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl E. Stine</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Himes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Earl E. Stine, Adamstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental retardation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12 Jan, 1959</u> , to <u>14 Jan, 1959</u> , that I last saw the deceased alive on <u>12 Jan, 1959</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Guest</u>		DATE SIGNED <u>7 E. Church St</u>	
PHYSICIAN'S NAME (Type) <u>R. L. GUEST</u>		<u>Frederick, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Md. Unionville</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>		24a. REC'D BY REGISTRAR <u>Walker, Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. E. Hines</u>		DATE <u>JAN 19 59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SERVICE</p> <p>12. PLACE OF DEATH</p> <p>13. DATE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF PHYSICIAN</p> <p>18. SIGNATURE OF REGISTRAR</p> <p>19. SIGNATURE OF WITNESS</p> <p>20. SIGNATURE OF DECEASED</p>		<p>21. NAME OF PHYSICIAN</p> <p>22. ADDRESS OF PHYSICIAN</p> <p>23. SIGNATURE OF PHYSICIAN</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. SIGNATURE OF WITNESS</p> <p>26. SIGNATURE OF DECEASED</p>
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CERTIFICATE OF DEATH

Reg. Dist. No.

00632

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1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM MEARL THOMAS		4. DATE OF DEATH Month Day Year JAN 7 1959	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 22-1908
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACK LAYOPER		10b. KIND OF BUSINESS OR INDUSTRY B.T.O. RAILROAD	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME WALTER H. THOMAS		14. MOTHER'S MAIDEN NAME IDA PEACH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 722-05-4900	
17. INFORMANT IDA THOMAS		Address MT AIRY MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular-renal disease DUE TO (c) 2 years			INTERVAL BETWEEN ONSET AND DEATH 1 month.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/6 , 19 59 , to 1/7 , 19 59 , that I last saw the deceased alive on 1/7 , 19 59 , and that death occurred at 6:10 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 1/7/59	
PHYSICIAN'S NAME (Type) Henry V. Chase		Frederick MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN 10-1958	22c. NAME OF CEMETERY OR CHAPEL SIMPSON'S CHAPEL	22d. LOCATION (City, town, or county) (State) NEW MARKET MD
23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Falconer		ADDRESS New Market MD	
24a. REC'D BY REGISTRAR JAN 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00633

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland		d. STREET ADDRESS 1308 N. Market Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crutchley Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Ritchie Last Titus		4. DATE OF DEATH Month January Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1872
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Adamstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Scarff		14. MOTHER'S MAIDEN NAME Eliza Norris Douglas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Martin Ritchie		Address 1308 N. Market St. Fred.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 15, 1959 to Jan 15, 1959 that I last saw the deceased alive on Jan 15, 1959 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE B. O. Thomas M.D.		Jan 17, 1959	
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr. M.D. 228 N. Market Street. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 19, '59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dauby Jr.		24a. REC'D BY REGISTRAR DATE	
ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE DATE	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

610

CERTIFICATE OF DEATH

00634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB 6 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy-Rural R. F. D. #4		d. STREET ADDRESS Emerson Burrier Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LaRUE Middle HETTIE Last TRESSLER		4. DATE OF DEATH Month January Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 3 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Vincent Fox		14. MOTHER'S MAIDEN NAME Mabel Lizzie Hesson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Carl A. Tressler-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 584x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary atelectasis (postoperative) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholecystitis, cholelithiasis & choledocholithiasis INTERVAL BETWEEN ONSET AND DEATH 72 hrs			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29 , 19 58 , to 1/3 , 19 59 , that I last saw the deceased alive on 1/3 , 19 59 , and that death occurred at 8:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 1/4/59 ACTUAL SIGNATURE Melvin E. Lea M.D. PHYSICIAN'S NAME (Type) Dr. Melvin E. Lea, Surgeon Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Central Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24. REC'D BY REGISTRAR JAN 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

CERTIFICATE OF DEATH

619

PLACE OF DEATH HOME		COUNTY BALTIMORE	
SEX MALE		AGE 61	
RACE WHITE		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 10 1955		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH DEC 10 1893	
NAME OF DECEASED JOHN VINCENZO TORRE		NAME OF NEXT OF KIN MRS. TORRE	
ADDRESS 1111 N. E. ST. BALTIMORE, MD		SIGNATURE OF DECEASED (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

This is to certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of January, 1955.
 J. B. KOSCIUSKO, Registrar
 J. B. KOSCIUSKO, Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

611

CERTIFICATE OF DEATH

Reg. Dist. No.

00635

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> <u>06X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Frederick City Hospital</u>		d. STREET ADDRESS <u>Route # 2</u>	
3. NAME OF DECEASED (Type or print) <u>(BABY BOY)</u> First <u>Waltz</u> Middle <u>Waltz</u> Last <u>Waltz</u>		4. DATE OF DEATH <u>Jan.</u> <u>28</u> <u>1959</u> Month <u>28</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27, 1959</u>
9. AGE (In years last birthday) yrs. <u>24</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frederick Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Earl Waltz</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Woodward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7-5445</u>	
17. INFORMANT <u>W. Earl Waltz, Westminster RD #2 Md.</u>		Address <u>Westminster RD #2 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7545 Congenital Heart Disease</u> DUE TO (b) <u>7545</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>7545</u> DUE TO (c) <u>7545</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 27, 1959</u> , to <u>Jan 28, 1959</u> , that I last saw the deceased alive on <u>Jan 28, 1959</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard O. Thomas Jr.</u>		DATE SIGNED <u>1/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas Jr.</u>		ADDRESS (Street, city or town, state) <u>238 N. Market St. Frederick Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 29, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr. Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>FEB 2 '59</u>	

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

612

CERTIFICATE OF DEATH

Reg. Dist. No.

00636

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>7 W. 6th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Donna Renee Weedon</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1959</u>		9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Winston Weedon</u>				14. MOTHER'S MAIDEN NAME <u>Clara Jane Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - Immaturity - Fetal Abnormalities</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 days</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Jan.</u> , 19 <u>59</u> , to <u>28 Jan.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 Jan.</u> , 19 <u>59</u> , and that death occurred at <u>9 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 N. Market St. Frederick, Md.</u> DATE SIGNED <u>1 Feb 1959</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				DATE SIGNED <u>1 Feb 1959</u>			
PHYSICIAN'S NAME (Type) <u>Dr. M. Powell, Jr.</u>				ADDRESS <u>Frederick, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicko III</u>				ADDRESS <u>24 W. All Saints</u>		24a. RECEIVED BY REGISTRAR DATE <u>FEB 4 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

2069234XVI

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John William Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>April 15, 1968</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. ICD-9 CODE <i>410.91</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Jane Smith</i>	
13. SIGNATURE OF DECEASED <i>John William Smith</i>		14. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		15. SIGNATURE OF BURIAL OFFICIAL <i>John Doe</i>	
16. SIGNATURE OF VENDOR <i>John Doe</i>		17. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		18. SIGNATURE OF CEMETERY <i>John Doe</i>	
19. SIGNATURE OF CHURCH <i>John Doe</i>		20. SIGNATURE OF MINISTRY <i>John Doe</i>		21. SIGNATURE OF OTHER <i>John Doe</i>	
22. SIGNATURE OF OTHER <i>John Doe</i>		23. SIGNATURE OF OTHER <i>John Doe</i>		24. SIGNATURE OF OTHER <i>John Doe</i>	
25. SIGNATURE OF OTHER <i>John Doe</i>		26. SIGNATURE OF OTHER <i>John Doe</i>		27. SIGNATURE OF OTHER <i>John Doe</i>	
28. SIGNATURE OF OTHER <i>John Doe</i>		29. SIGNATURE OF OTHER <i>John Doe</i>		30. SIGNATURE OF OTHER <i>John Doe</i>	
31. SIGNATURE OF OTHER <i>John Doe</i>		32. SIGNATURE OF OTHER <i>John Doe</i>		33. SIGNATURE OF OTHER <i>John Doe</i>	
34. SIGNATURE OF OTHER <i>John Doe</i>		35. SIGNATURE OF OTHER <i>John Doe</i>		36. SIGNATURE OF OTHER <i>John Doe</i>	
37. SIGNATURE OF OTHER <i>John Doe</i>		38. SIGNATURE OF OTHER <i>John Doe</i>		39. SIGNATURE OF OTHER <i>John Doe</i>	
40. SIGNATURE OF OTHER <i>John Doe</i>		41. SIGNATURE OF OTHER <i>John Doe</i>		42. SIGNATURE OF OTHER <i>John Doe</i>	
43. SIGNATURE OF OTHER <i>John Doe</i>		44. SIGNATURE OF OTHER <i>John Doe</i>		45. SIGNATURE OF OTHER <i>John Doe</i>	
46. SIGNATURE OF OTHER <i>John Doe</i>		47. SIGNATURE OF OTHER <i>John Doe</i>		48. SIGNATURE OF OTHER <i>John Doe</i>	
49. SIGNATURE OF OTHER <i>John Doe</i>		50. SIGNATURE OF OTHER <i>John Doe</i>		51. SIGNATURE OF OTHER <i>John Doe</i>	
52. SIGNATURE OF OTHER <i>John Doe</i>		53. SIGNATURE OF OTHER <i>John Doe</i>		54. SIGNATURE OF OTHER <i>John Doe</i>	
55. SIGNATURE OF OTHER <i>John Doe</i>		56. SIGNATURE OF OTHER <i>John Doe</i>		57. SIGNATURE OF OTHER <i>John Doe</i>	
58. SIGNATURE OF OTHER <i>John Doe</i>		59. SIGNATURE OF OTHER <i>John Doe</i>		60. SIGNATURE OF OTHER <i>John Doe</i>	
61. SIGNATURE OF OTHER <i>John Doe</i>		62. SIGNATURE OF OTHER <i>John Doe</i>		63. SIGNATURE OF OTHER <i>John Doe</i>	
64. SIGNATURE OF OTHER <i>John Doe</i>		65. SIGNATURE OF OTHER <i>John Doe</i>		66. SIGNATURE OF OTHER <i>John Doe</i>	
67. SIGNATURE OF OTHER <i>John Doe</i>		68. SIGNATURE OF OTHER <i>John Doe</i>		69. SIGNATURE OF OTHER <i>John Doe</i>	
70. SIGNATURE OF OTHER <i>John Doe</i>		71. SIGNATURE OF OTHER <i>John Doe</i>		72. SIGNATURE OF OTHER <i>John Doe</i>	
73. SIGNATURE OF OTHER <i>John Doe</i>		74. SIGNATURE OF OTHER <i>John Doe</i>		75. SIGNATURE OF OTHER <i>John Doe</i>	
76. SIGNATURE OF OTHER <i>John Doe</i>		77. SIGNATURE OF OTHER <i>John Doe</i>		78. SIGNATURE OF OTHER <i>John Doe</i>	
79. SIGNATURE OF OTHER <i>John Doe</i>		80. SIGNATURE OF OTHER <i>John Doe</i>		81. SIGNATURE OF OTHER <i>John Doe</i>	
82. SIGNATURE OF OTHER <i>John Doe</i>		83. SIGNATURE OF OTHER <i>John Doe</i>		84. SIGNATURE OF OTHER <i>John Doe</i>	
85. SIGNATURE OF OTHER <i>John Doe</i>		86. SIGNATURE OF OTHER <i>John Doe</i>		87. SIGNATURE OF OTHER <i>John Doe</i>	
88. SIGNATURE OF OTHER <i>John Doe</i>		89. SIGNATURE OF OTHER <i>John Doe</i>		90. SIGNATURE OF OTHER <i>John Doe</i>	
91. SIGNATURE OF OTHER <i>John Doe</i>		92. SIGNATURE OF OTHER <i>John Doe</i>		93. SIGNATURE OF OTHER <i>John Doe</i>	
94. SIGNATURE OF OTHER <i>John Doe</i>		95. SIGNATURE OF OTHER <i>John Doe</i>		96. SIGNATURE OF OTHER <i>John Doe</i>	
97. SIGNATURE OF OTHER <i>John Doe</i>		98. SIGNATURE OF OTHER <i>John Doe</i>		99. SIGNATURE OF OTHER <i>John Doe</i>	
100. SIGNATURE OF OTHER <i>John Doe</i>		101. SIGNATURE OF OTHER <i>John Doe</i>		102. SIGNATURE OF OTHER <i>John Doe</i>	

613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick County Chronic Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOURREN Middle LESLIE Last WELTY, SR.		4. DATE OF DEATH Month January Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 7, 1877
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 24 Days 15	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lime Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Welty		14. MOTHER'S MAIDEN NAME Amanda Geesey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-1576	
17. INFORMANT R.F.D.#3, Mr. Robert M. Welty, Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 H. 24 H.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 24, 1958 , to Jan 4, 1959 , that I last saw the deceased alive on Jan 4, 1959 , and that death occurred at 6:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market Street DATE SIGNED 1/6/59 ACTUAL SIGNATURE H. F. Kline M.D. PHYSICIAN'S NAME (Type) Dr. H. F. Kline Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR JAN 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES J. JONES		MALE		35	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JANUARY 10, 1919		AT HOME		HEART DISEASE	
TIME OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
10:30 P.M.		NATURAL		CORONARY ARTERY DISEASE	
PLACE OF BIRTH		EDUCATION		OCCUPATION	
NEW YORK		HIGH SCHOOL		LABORER	
DATE OF BIRTH		MARRIAGE		PREVIOUS ILLNESS	
JANUARY 10, 1884		MARRIED		NONE	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF MINISTER	
DR. J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER	
DATE OF REGISTRATION		PLACE OF REGISTRATION		OFFICE OF REGISTRATION	
JANUARY 10, 1919		AT HOME		STATE DEPARTMENT OF HEALTH	

00639

MEDICAL CERTIFICATION

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